EXHIBIT B

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.emblemhealth.com** or by calling **1-800-624-2414**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 individual/$500 family for out-of-network only.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	No	Not applicable because there's no **out-of-pocket limit** on your expenses.
What is not included in the out–of–pocket limit?	Co-payments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.EmblemHealth.com or call 1-877-842-3625 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay	0% co-insurance	----None----
	Specialist visit	$20 co-pay	0% co-insurance	Does not apply to all specialists.
	Other practitioner office visit	$15 co-pay	0% co-insurance	----None----
	Preventive care/screening/immunization	$15 co-pay	0% co-insurance	----None----
If you have a test	Diagnostic test (x-ray, blood work)	$15 co-pay	0% co-insurance	----None----
	Imaging (CT/PET scans, MRIs)	$15 co-pay	0% co-insurance	Pre-certification required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.EmblemHealth.com.	Generic drugs	Not covered	Not covered	----None----
	Preferred brand drugs	Not covered	Not covered	----None----
	Non-preferred brand drugs	Not covered	Not covered	----None----
	Specialty drugs	Not covered	Not covered	----None----

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Please check with your employer.
	Physician/surgeon fees	Covered	0% co-insurance	----None----
If you need immediate medical attention	Emergency room services	Not covered	Not covered	----None----
	Emergency medical transportation	Not covered	20% co-insurance	----None----
	Urgent care	$15 co-pay	0% co-insurance	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	----None----
	Physician/surgeon fee	Covered	0% co-insurance	----None----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay	Subject to New York City non-participating benefit $200/$500 calendar year deductible	No lifetime maximum
	Mental/Behavioral health inpatient services	$300 co-pay per admission	$500 co-pay per admission/$1250 maximum per calendar year	20% to max of $2,000 per person per calendar year
	Substance use disorder outpatient services	$15 co-pay	Subject to New York City non-participating benefit $200/$500 calendar year deductible	No lifetime maximum
	Substance use disorder inpatient services	$300 co-pay per admission	$500 co-pay per admission/$1250 maximum per calendar year	----None----
If you are pregnant	Prenatal and postnatal care	No charge	0% co-insurance	----None----
	Delivery and all inpatient services	No charge	0% co-insurance	----None----

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	$50 deductible per episode; 20% co-insurance	200 visits per member per year. Pre-certification required.
	Rehabilitation services	$15 co-pay	0% co-insurance	16 visits per calender year
	Habilitation services	$15 co-pay	0% co-insurance	
	Skilled nursing care	Not covered	Not covered	----None----
	Durable medical equipment	$100 deductible	$100 deductible; 50% of usual and customary charge	Pre-certification required on greater than $2,000
	Hospice service	Not covered	Not covered	----None----
If your child needs dental or eye care	Eye exam	Not covered	Not covered	----None----
	Glasses	Not covered	Not covered	----None----
	Dental check-up	Not covered	Not covered	----None----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact EmblemHealth at 1-800-624-2414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact EmblemHealth.

All hospital grievances should be mailed to: EmblemHealth-Hospital Grievance P.O. Box 2828 New York, New York 10116-2828 All other grievances should be mailed to: EmblemHealth-Grievance Unit P.O. Box 1701 New York, New York 10023-9476 Oral Utilization Review Appeals can be initiated by calling toll free 888-906-7668.	Or you may submit a written appeal to: EmblemHealth Utilization Review Appeals P.O. Box 2809 New York, NY 10116-2809 You may also obtain an external appeal application from: The New York State Department of Financial Services at 1-800-400-8882, or its Web site (www.dfs.ny.gov/), or The EmblemHealth Medical/Utilization Review Department at 1-877-482-3625

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-2414.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414.

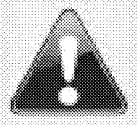
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-2414.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-2414

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7315
- **Patient pays** $225

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$75
Co-insurance	$0
Limits or exclusions	$150
Total	$225

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-624-2414.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** 4125.47
- **Patient pays** 1274.53

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$535
Co-insurance	0
Limits or exclusions	$739.53
Total	1274.53

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-624-2414.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.emblemhealth.com** or by calling **1-800-624-2414**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 individual/$500 family for out-of-network only.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	No	Not applicable because there's no **out-of-pocket limit** on your expenses.
What is not included in the out–of–pocket limit?	Co-payments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.EmblemHealth.com or call 1-877-842-3625 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay	0% co-insurance	----None----
	Specialist visit	$20 co-pay	0% co-insurance	Does not apply to all specialists.
	Other practitioner office visit	$15 co-pay	0% co-insurance	----None----
	Preventive care/screening/immunization	$15 co-pay	0% co-insurance	----None----
If you have a test	Diagnostic test (x-ray, blood work)	$15 co-pay	0% co-insurance	----None----
	Imaging (CT/PET scans, MRIs)	$15 co-pay	0% co-insurance	Pre-certification required.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.EmblemHealth.com.	Generic drugs	Retail-30 days supply-2 fills; Deductible $150 ind/$450 fam; 20% co-insurance with min charge of $5 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; $10 co-pay. Prescriptions will not be filled at retail after 2 fills.
	Preferred brand drugs	Retail-30 days supply-2 fills; Deductible $150 ind/$450 fam; 40% co-insurance with min charge of $25 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; $40 co-pay. Prescriptions will not be filled at retail after 2 fills. Prior-authorization is required for certain brand name medications.
	Non-preferred brand drugs	Retail-30 days supply-2 fills; Deductible $150 ind/$450 fam; 50% co-insurance with min charge of $40 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; $60 co-pay. Prescriptions will not be filled at retail after 2 fills.
	Specialty drugs	Covered	Not covered	Must be dispensed by the Specialty Pharmacy Program Provider.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	----None----
	Physician/surgeon fees	Covered	0% co-insurance	----None----
If you need immediate medical attention	Emergency room services	Not covered	Not covered	----None----
	Emergency medical transportation	Not covered	20% co-insurance	----None----
	Urgent care	$15 co-pay	0% co-insurance	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	----None----
	Physician/surgeon fee	Covered	0% co-insurance	----None----

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay	Subject to New York City non-participating benefit $200/$500 calendar year deductible	No lifetime maximum
	Mental/Behavioral health inpatient services	$300 co-pay per admission	$500 co-pay per admission/$1250 maximum per calendar year	20% to max of $2,000 per person per calendar year
	Substance use disorder outpatient services	$15 co-pay	Subject to New York City non-participating benefit $200/$500 calendar year deductible	No lifetime maximum
	Substance use disorder inpatient services	$300 co-pay per admission	$500 co-pay per admission/$1250 maximum per calendar year	----None----
If you are pregnant	Prenatal and postnatal care	No charge	0% co-insurance	----None----
	Delivery and all inpatient services	No charge	0% co-insurance	Enhanced schedule increases the reimbursement of the basic program's non-participating provider fee schedule, on average, by 75%.
If you need help recovering or have other special health needs	Home health care	No charge	$50 deductible per episode; 20% co-insurance	200 visits per member per year. Pre-certification required.
	Rehabilitation services	$15 co-pay	0% co-insurance	16 visits per calender year
	Habilitation services	$15 co-pay	0% co-insurance	
	Skilled nursing care	Not covered	Not covered	----None----
	Durable medical equipment	$100 deductible	$100 deductible; 50% of usual and customary charge	Pre-certification required on greater than $2,000
	Hospice service	Not covered	Not covered	----None----
If your child needs dental or eye care	Eye exam	Not covered	Not covered	----None----
	Glasses	Not covered	Not covered	----None----
	Dental check-up	Not covered	Not covered	----None----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
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For more information on your rights to continue coverage, contact EmblemHealth at 1-800-624-2414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

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If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact EmblemHealth.

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free 888-906-7668.	

Language Access Services:

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Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-2414.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-2414

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7165
- **Patient pays** $375

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$150
Co-pays	$75
Co-insurance	$0
Limits or exclusions	$150
Total	$375

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-624-2414.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4675
- **Patient pays** $725

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$150
Co-pays	$535
Co-insurance	$0
Limits or exclusions	$40
Total	$725

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-624-2414.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.